ORIGINALITY OF ESSAY

Except where otherwise acknowledged, the work described in this essay is my own original work.

Peter Fox

An Occupational Mental Health Program to Government Employee Unions in the A.C.T. - Report, Area and Issues

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SUMMARY

This essay presents a report of an Occupational Mental Health program to a number of public service employee organisations in the A.C.T. The main psychological services provided were clinical consultation and mental health training - based on a community mental health model.

A number of similar programs carried out overseas are presented and issues arising from them are explored in relation to the above program.

Some theoretical issues of special interest are explored, including the Person-Environment fit model and the relationship between organisation and family concepts.

Finally, conclusions are drawn in regard to the applicability of the community mental health model to the occupational mental health program described and in regard to the engagement of the union organisations. It is recommended that a Peer Counselling Model would be a better fit for the above program under the same industrial circumstances and that engaging a client system as large and fragmented as a union organisation requires special and expert attention.

CONTENTS

INTRODUCTION

The purpose of this essay is first, to report an exploratory application of a community mental health model to a section of the industrial community represented by a number of A.C.T. government employee unions. Second, to explore some of the practical and theoretical issues that arose from the impact of developing a mental health role within a union organisation on a clinical psychologist, whose prior training and work was individual and family counselling and psychotherapy in a health organisation.

The scope of this essay is broadly covered by the rubric Occupational Mental Health (abbreviated hereafter as OMH) which spans many disciplines and penetrates many fields e.g. rehabilitation, occupational health, well-being and safety, quality of working life, office and machine design, etc etc. More specifically, this essay covers OMH programs delivered either through or with the cooperation of employee organisations and for mentally and emotionally distressed people in the work place.

Excluded from the essay is an exploration of the role of the psychologist and OMH (see Conant (1969), Ferguson D. etal (N.H. & M.R.C.), the nature of work itself and its impact on mental health (see O'Toole (1973 and 1974)) and the impact of an employees mental health problems on his job or on his organisation (see e.g. Wansborough (1977), McLean (1967)).

The community mental health model referred to above has three basic principles. First, that mental health problems occur within an environment and that the interraction between the individual and his/her environment is of prime importance to understanding the identified person's problems and to implementing effective treatment and preventative interventions. Second, community mental health has a focus on prevention, early recognition and treatment, and rehabilitation with a minimum of dislocation of the person from their environment. Third, in the practice of community mental health, the role of the health worker involves interractions on many levels within the environment of the identified person and including a variety of modes of interraction including consultation, collaboration, participation, administration, etc. (Longaker p218 (1972)).

I have, used a working definition of mental health derived by Kasl (p172 in O'Toole (1974)) by grouping partial indicators of mental health into four categories. These are:

".Indices of functional effectiveness or role performance reflect (ing) a sociological orientation and their measurement focuses on quantifying the extent to which a person is unable to perform his usual duties and activities, especially those connected with primary social roles. Hospitalization, absence from work, quitting a job, and deserting a spouse are some examples of this class of mental health criteria.

.Indices of well-being including affective measures (depression, resentment), symptomatic measures (tension, jitters) and the various measures of self-evaluation and satisfaction (self-esteem, job satisfaction, life satisfaction, need satisfaction).

.Indices of mastery and competence, which are emphasised by those with a humanistic orientation to mental health, are positive criteria that include growth and self-actualisation, adequacy of coping, use of valued skills and attainment of valued goals.

.Psychiatric signs and symptoms include (-ing) dimensions that are not readily classified into one of the other categories and yet are considered to be clinically significant by the discipline of psychiatry. One is the perception of reality." (Kasl p172 op cit)[1]

I have found in practice that the concept of mental health raises issues of labelling and stigma which are not helpful to mutual understanding. Therefore, I have tended to use the concept of stress and its effects on health, familiar to lay people, as a bridge to allow passage of the concept of mental health. Here, I have grown to prefer a description of stress from House (p146-148 in O'Toole 1974) He points out that "what we commonly call (work) stress is a product of the relationship between individuals and their job situations. Hence the effects of stress are the result of a complex interplay between the individual and his environment." He describes five interrelated factors that derive from that complext interplay (and which define the area of stress reasearch). These are:

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1. Kasl goes on to say that the very multiplicity of these categories indicate "that one index is not an adequate substitute for another. Moreover, a useful index of mental health is not generated by averaging all the separate indices. We should be interested in the empirical association among them. For example, there are several community follow-up studies of discharged mental hospital patients that indicate a very low correspondence between symptomatology and psychosocial functioning. Using a variety of criteria should alert us to the difficulties of interpreting some of the traditional behavioural measures. For example, absenteeism from work may be seen as an indication of inadequate role performance, but it may also reflect coping with some job stress and thus contribute positively to mental well being." (Kasl, p172-173, op cit).

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".the objective conditions of work conducive to stress.
.Individual perceptions of work situations as stressful.
.Individual responses to perceived stresses.
.Outcomes of perceived stresses.
.Individual and social situational characteristics that condition the relationships among the first four factors." (Haise p146-147 op cit.)

In order to predict the health and well-being outcomes of given conditions of work one requires knowledge of these five factors and their interractions.

SECTION 1

An Occupational Mental Health Program to the Council of Australian Government Employee Organisations (CAGEO) A.C.T. Division.

Preface

Prior to entering the second year of the Masters course (part-time), the Health Commission Branch for which I work, was approached by CAGEO (A.C.T.) requesting the services of a "psychologist-counsellor". This was my first contact with the organisation and though limited inscope, sufficient trust was established to be able to request a placement as a Masters Student (see Appendix 1).

Background

Initial discussion with officers of CAGEO, Dr Gladstones and myself raised the following service requirements:

1. Clinical counselling and consultation - union officers and organisers are regularly approached by members presenting with both recurring and acute non-industrial-related problems. As well, members with industrial problems (e.g. pay and conditions of service most frequently) present with a range of mild to severe emotional reactions to these problems. The problems of these members are often intermingled with problematic and/or adverse work environments - some of which are notorious in this regard, and produce an irregular flow of casualties.

Provision of a mental health counselling and consultation service is a partial solution to this significant aspect of the work of unions affiliated with CAGEO.

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2. Mental health training - another part of the solution is to raise the level of skill amongst union officers and organisers in assessing, counselling and referring members who present with non-industrial-related problems. This would also allow a significant contribution to the easing of distress and to future prevention for those members reacting to industrial problems maladaptively.

3. Research - a number of research proposals were raised. Firstly, to identify the extent, nature and location of the above problems in the public service. This would permit detection of trouble spots and it was thought diagnosis of organisational factors involved. One of these factors was identified as that of stratification e.g. in the Defense department between fourth division civilians and military staff; and in Attorney Generals' department between non-professional staff and lawyers. Secondly, some of the unions' difficulties in handling these particular classes of member's problems, arise from the stigma attached to the union movement. This manifests itself in the practice of consulting the union as a last resort when the members problem has developed almost beyond help.

INITIAL PLAN OF ACTION

1. Provide clinical consultation primarily.

2. Develop training programs for union officials, organisers and shop stewards.

3. Develop a research project on the pattern of consultation of public servants in distress - outlined in Appendix III

Focal Office

I placed myself for one day a week at the offices of the Australian Public Service Association, Fourth Division Officers (APSA/FDO) over a period of about seven months. I was available to all the ten affiliated unions of CAGEO as well as the Australian Workers Union (AWU) Welfare officer, and the Trade Union Training Authoritiy (TUTA). The affiliates with whom I had most contact were APSA., the Association of Architects, Engineers and Surveyors of Australia (AAESDA), Administrative and Clerical Officers Association (ACOA), the A.C.T. Police Association and C.S.IR.O. Technical Officers Association.

APSA (FDO) is operated by an Executive Committee (president, Secretary, Assistant Secretary, Senior Deputy President, Deputy President) and a Committee of Management (nine elected members). The APSA office contained five full-time paid workers, (Secretary, Assistant Secretary, Industrial Officers and two secretarial staff). Most public service offices where members work have unpaid, part-time office representatives (shop stewards) who handle enquiries and distribute journals etc,. The secretary of APSA who supervised my placement, was also secretary of CAGEO (A.C.T.).

Results

1. Clinical Consultation and Counselling

Most union officials expect to spend 50% of their time in dealing with members whose problems are not directly industrial related. (This was confirmed by interview with a number of officials and questionnaire to ACOA candidates before a branch election).

Some union officials and organisers are particularly skilled and strongly inclined to a welfare-counselling role and are recognised as such by the membership, often before they work directly for the union. These "lay" helpers (usually trained only by experience) were the most frequent users of clinical consultation. Others, who were more likely to be struggling with the welfare role, were ironically, more likely to consult when all else had failed. I met some union officials and organisers who were not struggling with the welfare role and who were not sensitive to the emotional distress occassioned by the industrial problems of members.

I placed a high priority on retaining a consultative role, firstly, to avoid raising the expectations of the union organisations I have involved , so that when I left at the end of the year an expectation would not arise which I could not fulfil or channel elsewhere. Secondly, to emphasise the present clinical resources available within and outside of the unions. Finally, to free myself from a burdensome caseload, which at the time I lacked the industrial experience to handle in the broad context. Therefore, I collaborated directly with union officials and a small number of seriously disturbed members. The remainder of clinical consultation required most frequently a ten minute discussion over the phone and locating the appropriate agency for referral.

In none of the seriously disturbed cases, was it necessary to take on responsibility for management of the members problem, that remained with the union

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official. That was also the expectation of the member.

I have briefly tabulated those seriously disturbed members below according to an abbreviated W.H.O. classification and emphasising in columns, the unique population that comes to the union.

W.H.O Classification	Known* Present or Past Client of Public or Private Mental Health Service	Not known* as Client of any M. Health Service
Schizoid and Paranoid States	1- Case A	-
Depressive Neurosis	1	-
Other Neurosis and Psychosomatic	1- Case B	-
Alcohol and Drug Dependence	-	2- Case D
Other Personality Disorder	-	3
Transient Situational Disturbance at Work	-	8- Case C
T.S.D. not at Work	-	1
No Psychiatric Diagnosis	-	2- Case E

*Admitted by Client

I cite below a brief outline of some representative cases, suitably altered to protect the persons concerned.

Case A

Mr A, aged 25 years a war veteran, currently a clerical assistance in Public Service, approached a union with a written complaint. In part it said "Whilst working at (the office) or even driving the car around Canberra, I am conscious that aircraft appear to tap out my thinking, comments or reading and writing. I see my problem on par of a KGB car and person using a megaphone as loud and frequently as the aircraft, asking Public Servants to divulge information." Mr A did not handle any classified material.

He has a history of paranoid schizophrenia and has been treated for psychiatric breakdown once in 1970 and again in 1972. During times of freedom from paranoid thoughts he has been able to perform a clerical job successfully and with promotion.

He approached the union for their help in investigating and stopping his mind being read and in negotiating with Department of Repatriation, whom he claimed were threatening to increase his pension against his wishes.

..../ 7

He did not wish to go back to a public psychiatrist who had treated him in 1975. He was near to a further breakdown and recognised that his paranoid thoughts were causing him much suffering.

I saw him on two occassions with the union official and encouraged him to accurately assess his situation and return to the psychiatrist for medication. I subsequently discovered that he did return of his own accord to the psychiatrist, two days after I last saw him.

Case B

Mr B. aged 49 years, married with a grown-up family still living at home, and working as a Supervisor in a Public Service industrial plant. He had been there for the whole of his working life and one of his kin also worked there. Mr B. had approached his union some months before I became involved, requesting advocacy to management. Conflict had arisen primarily after a piece of equipment that he had worked with for 30 years was replaced by a modern and less flexible one. A significant number of alterations in the primary produce that entered the plant, had put the economic efficiency of the new plant under threat. In addition, to being blamed for the unexpected inefficiency of the new plant, Mr B. was inadequately prepared for operation of the plant. The dispute culminated once when management alleged Mr B. had sabotaged the equipment and removed him from operating the plant (enter the union); and again when Mr B. sustained an industrial injury and was laid off work on compensation - (enter myself).

Management was hostile to his return to work and Mr B. was becoming increasingly psychologically injured. The machinations surrounding this case would take pages, suffice to say that Mr B. was developing a psychological incapacity to return to work as well as incapacitating low back pain.

I collaborated with the union official in a number of interviews with Mr B and with the directors of the industry and factory management. Our aim was a satisfactory return to work. Mr B. was, however, compensated out of work over a year later.

Case C

Mr C. aged 47 years, a new Australian of about 10 years duration, working as a clerical assistant in a tertiary industry. Due to extensive photographic experience and expertise, derived in his country of origin, he held an informal position of considerable importance to the organisation. He was unqualified by Public Service standards, to fill such a position formally, and so received no financial rewards. However, he was rewarded by the organisation informally and by occupying a handsome office and having free access to valuable photographic equipment. He undertook his formal duties efficiently and operated the equipment mostly in his own time. When Mr C. first approached his union it was as a result of the actions of a newly created and appointed administrator. The administrator had a history of generating staff conflicts and in one place a union walk-out. Mr C. reported that the administrator had taken an "instant dislike" to him. He had systematically taken the informal rewards, the office and free access to the equipment from Mr C. - by the regulations and the rule book. Mr C. remained the only one in the organisation who could operate the equipment and he did so when asked. This continued a long process of victimization by the administrator, which eventually led to Mr C's physical and mental breakdown - and a total of six months off work.

I saw Mr C. with the union official at the conclusion of this process and acted as a consultant in a minor way. Mr C. eventually obtained a transfer, and has been in good health since.

...../8

Case D

Mrs D, a shop assistant in her mid-40's, was referred to her union by her boss as he was going to dismiss her that day. That job was secured for her by her union previously, after she had been dismissed on a security breach, from another department store. That security breach was in the unions opinion insufficient to justify dismissal and would not normally have led to this action except for the presence of an interstate security supervisor. Mrs D. remained very angry about this.

Nevertheless, the union official had obtained the present job in a store with favourable management. The style of work was different from the previous job, involving sitting around for periods with nothing to do. This was a style which Mrs D. found difficult to cope with. Her performance on the job was unsatisfactory - one day a week off sick, on other days surly and unhelpful to customers.

I interviewed Mrs D. with the union official on the day of dismissal from this second job. She was deteriorated in appearance. She reported a number of serious life stresses in the recent past and currently was struggling to pay substantial medical bills, as well as the loan on her house and car. Her husband is an alcoholic holding a senior management position in Public Service. The union organiser was particularly concerned about Mrs D's reported drug abuse.

Mrs D. was understandably, not amenable to counselling. Her situation required a miracle it seemed to me at the time. She was obtaining adequate supportive counselling from her union and they were attempting to arrange another placement. I recommended referral for counselling if this failed. She was not referred.

Case E

In fact this case involves part of a team and the part-time union official. The most extensive work was done with Mrs E. Mrs E, in her early 40's is a new Australia of about 20 years duration, works as a temporary employee in a research establishment and has been in this job for 2 years. Mrs E has taken considerable sick leave during these years. I first interviewed Mrs E with the part-time union official who works in a adjacent area and with one past and one present member of the team. The past member, Mrs F in her mid 50's recently took another job at $2,000 p.a. less, in order to leave the team. The present member, Mr G, aged 30 has worked for 9 years in this team and has tried unsuccessfully to transfer to other positions in the same division. All four ventilated considerable distress at the interview, Mrs E. crying at one stage. The focus of their distress is the supervisor of the team, Miss H. who has been in that job for 2 years. The previous occupant of her job was Mr I. (who is now Miss H's supervisor). There has been a history of conflict between Mr I and Miss H and he avoids this conflict now by not exercising authority over Miss H. - whose research procedures are at variance with the funding organisation and a source of further conflict for her.

Both Mrs E and Mr G complained of (a) work conditions e.g. long periods of intricate work, tension created by Miss H timing the workers even during toilet breaks, detailed work being set and once started being interrupted by Miss H and a completely new job set. (b) when no witness present being subjected to character attack and personal abuse by Miss H. (c) insinuation of bad reports being filed to prevent them applying for other positions. In the case of Mr G. he has to report his movements to Miss H. every half-hour. Miss H. has successfully appealled against one of his recent transfers.

The one other present member of the team who was not present at this interview is reported to work well with Miss H. One other recent member of the team not present was retired on medical grounds.

Mrs E. was identified as the most vulnerable person. Mr G. shortly after this interview secured a transfer.

.../9

I subsequently interviewed Mrs E. and her husband at home and maintained phone contact with her. I had frequent consultations with the union official and attempted, unsuccessfully, to have Mrs E. transferred. Mrs E. continued to have long periods off sick, even whilst the team spirit temporarily improved.

Eventually, over a year later, Mrs E. was compensated on medical grounds and ceased working.

Concluding Comments

I have slanted my case selection and descriptions to raise the variety of work environment contexts interacting with the members' problems rather than, say the social and psychological history of the member. My role with each case was congruent with the helping resources available in the union organisation, and particularly the short-term counselling goals that are practicable. Members will appear for and accept counselling whilst their work problem is current, but are unlikely to pursue longer term counselling goals. Often counselling is done with almost a slight-of-hand, where practical help and support is openly acknowledged. This is in part due to the climate and industrial work style of the union organisation (its structure).

The cases selected also underline the critical distance of the union official and clinical consultant from the significant others in the work environment of the troubled members. the case of Mr B was about as close as I got and then very late in the process.The case of Mrs E is a glaring example, where the supervisors participation would have been vital. The lateness of referral, long after the preciptating events, is likewise a result of this distance. It was the biggest handicap to successful intervention and return to work.

2. Training

Union officials, organ isers and shop stewards are approached by members experiencing as wide a range of stressful life events as the clientelle of a community, professional counselling service. The greatest difference is in the more frequent work context of the former and family context of the latter. However, it is a rare union official, etc., who has the equivalent initial and ongoing training and access to support and supervision.

Therefore, there is keen interest shown in counselling training by a variety of people and for a variety of motives. Two forums were initiated by Mr Don Ponitt, formerly Senior Research Psychologist, Capital Territory Health Commission, with whom I collaborated in this training.

..../10

The first was an eight session (each of 3 hours duration) counselling skills workshop, sponsored by the Health Commission, and begun before I was placed as a Masters' student in CAGEO.

The participants were twelve, full-time officials and union organisers (industrial officers) from CAGEO affiliated unions as well as the AWUWelfare Officer. Designed on a communications skills approach with critical incident role plays. The design derives from work of Carkhuff R.R. (1969), training in such skills as attentive listening, reflection of feeling and personal meaning, empathy, concreteness, etc. I was co-leader in this workshop.

The response was generally favourable and we were surprised by the high level of skill demonstrated by some of the participants. A second workshop was designed by myself and Mr Porritt in the light of our experiences both from the first course and from my clinical consultation. We decided to ask the Trade Union Training Authority (TUTA) to sponsor this in order to reach a wider audience than the CAGEO affiliates, and to reduce our administrative responsibility. Mr Porritt and I wrote a number of workshop aids (Fox and Porrit (1976), MacKenzie, Fox, and Porritt 1976, Porritt and Fox (1976)), three of which are attached - Appendix II. This second course was to be over four full days in February and March of 1977 with the fourth day occurring a month after the third. Unfortunately the course has yet to take place, due primarily to financial and"educational", pruning in TUTA, and my reticience in starting the course without an in-house sponsor - as I would like to train TUTA to run the course themselves.

The basic outline of this course is as follows - using the mixture of skills training and critical incident role play.

Day 1

Session I — Nature and sources of stress. Role of supports in coping with stressful life events. Crisis.

Session II — Identification of stress/supports and precipitating events in ones' own life and work. Working-with versus taking-over.

Session III — Overview of micro-skills - empathy, respect, genuiness and self-disclosure, constructive confrontation. Helpful and unhelpful people exercise; structuring the inquiry.

Session IV — Standing in anothers' shoes - an exercise in empathy. Attentive listening. Introduction to reflection of feeling.

..../11

Day 2

Session I — Reflection of feelings - practice role-plays.
Introduction to concept of personal meaning.

Session II — Personal meaning - practice role-plays.

Session III — The impact of this human relations approach on officials multiple and sometimes conflicting roles e.g. staying and working-with the feeling versus taking industrial action.
Introduction of concepts of owning your feelings and setting limits.

Session IV — Impact.ctd.
Exploration and practice of Role Negotiation skills.

Day 3

Session I — Review

Session II — Introduction of concept of constructive confrontation.
Role play practice of constructive confrontation.

Session III — Limit setting - role play practice.

Session IV — Looking forward.
Maintaining new learning through peer supervision.

Day 4 (one month later)

Recall

Problems

Discussion

Evaluation

At the suggestion of Mr Porritt, I decided to compile a pre- and post- measure to evaluate the effect of this course. The measures were based on an hypothesis that participants would alter their work environments and self perceptions after the course in favour of less role conflict and less role ambiguity and less resource deficiency (e.g. acquiring more adequate resources to fulfil the job expectations and thus reduce role overload.)

The measure, compiled as a battery of questionnaires, namely:

1. "Team Work Questionnaire" - designed by Mr Porritt aimed at illuminating perceived resource deficiencies.

.../12

2. "Feelings about life" - a life stresses and satisfactions questionnaire used in the Canberra Mental Health Survey.

3. "Job-related tension Index" - derived from the questionnaire of the same name in Kahn R.L. etal (1964) and suitably altered for this course.

4. "Perceived Role Conflicts and Ambiguity" - a semi-structured interview derived from Kahn R.L. et al (1964) and suitable altered for this course.

This battery would have given me a qualitative picture of each participant's work style before and after the course. As I intended to question the participants myself this may have influenced them in the hypothesised direction.

The second forum was first begun by Mr Porritt at the invitation of TUTA, and subsequently continued by me. It was a one, three hour session in the Basic Shop Steward Course run by TUTA. The session is entitled "Assessing a Member's problems" and it was presented with a British film of the same name (though latterly an Australian film has been used). In the five sessions I have run I have emphasized the mental health issues e.g. in early case finding and prevention as well as the issues in the "learning cycle" referred to in the article "Helping Distressed People" (in Appendix II and handed out in these sessions). The session includes a role play of a member presenting with a problem

I have also initiated a session for the Advanced Shop Steward Course, in which I presented some practical solutions to common problems encountered by shop stewards. Two of these are contained in the article. "Taking-over and Working-Together" and "Negotiating a contract", included in Appendix II.

Finally, the Industries Assistance Commission sponsored a Joint union management exercise entitled Occupational Health Seminar. It was organised for Second Division Officers and Directors and I was invited to lead a session on stress and coping.

..../13

Concluding Comments

The training that was implemented consisted of an early case finding approach of detecting stress and a counselling strand that alerted trainees to the possibilities of responding helpfully in situations of ordinary and extraordinary distress. In each training forum, the clinical consultation service was offered to participants. Where this was subsequently used there was a handsome spin-off in reaching further into the lay referral network of the union organisation and sometimes in reaching cases earlier. Training thus served as a valuable OMH education that produced the beginnings of an early referral network.

.3 Research

The breadth of the research plan outlined in Appendix III required an initial collection of open field data from which to develop hypothese. This information could be obtained from such sources as the Promotions Appeals Committe (which is often used as a forum to air grievances which otherwise would not be heard), the Public Service Board as well as the unions affiliated with CAGEO. Furthermore, interviews with Personnel Officers and the "identified" troubled employees could ellicit further retrospective data.

The Public Service Boards cooperation would be crucial in obtaining access to this information. Consequently, I met with a Senior Inspector of the Board, who had previously supervised the placement of another Master's student at the Board. Mr. B. Guy (the result of this placement referred to in the Bibliography). It became apparent in that meeting, that this cooperation would be cautious, due to by my association with A.C.T. unions. I was told that access to the Board's library would be "frowned on" by some people in the Section".

I was told that: (1) personnel files contain little information about the process of consultation and referral of persons in trouble of personal details beyond administrative matters; (2) employees in trouble are often recognised by supervisors and by the organisation, but there is a tendency to apply disciplinary action rather than a mental health counselling approach. Then details of the trouble contained in the file

.../14

exclude the antecedent; (3) collection of retrospective data raises prohibitive problems in both broaching issues of confidentiality (then under review by the Joint Council of the Public Service) and in stirring old wounds by approaching the "identified" employee.

It must be said that at the time, the board may have been particularly sensitive to my approach as Commissioner Munroe of the Royal Commission to Australian Government Administration (himself associated with CAGEO - its federal secretary), was undertaking an intensive investigation of 100 cases of grievances some of whom may have been a distinct embarrassment to their departments.

Nevertheless, in the experience of some A.C.T. Union Officials, and in the grievance case studies of the R.C.A.G.A., There was a considerable amount of controversial material on personnel files. Some union members who had sighted their personnel file, believed the contents were adverse to their careers. Furthermore, the report of the Joint Council Sub-Committee on Staff Counselling and of the R.C.A.G.A. confirmed that there are a large number of people e.g. supervisors, personnel officers, training officers and welfare officers who detect and undertake counselling of troubled employees.

The Joint Council Sub-Committee discovered 961 such people from surveying 160 departmental offices. Some of the Industries Assistance Commission 2nd Division Officers who attended the aforementioned Seminar, reported this to be their most burdensome duty and one they were least prepared for.

As a result of the difficulties in obtaining satisfactory information from personnel files, I decided to reduce the reach of my research to only those employees who came into contact with CAGEO affiliated unions.

To obtain open field data from the unions in sufficient detail and quantity to develop hypotheses, required a data recording system. There was no systematic, coordinated or comparable record keeping of pertinent contacts with the unions with which I became familiar. A rare union worker kept a remarkably detailed journal of each contract, whilst another kept it all in his head. The worst examples of poor

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record keeping were also reflected in unsystematic and inconsistent supervision, evaluation and follow-up of casework - a pattern not unfamiliar in professional counselling services.

Consequently, I placed the task of developing a record keeping system as a priority, from which my research project could also arise. I developed, through collaboration with the AP.S.A. (F.D.O.) staff, an aggreeable and simple head count, case finding and recording device[2]. see Appendix IV. I realised from watching the work styles and recording habits of the union officials and organisers with whom I consulted, that a simple record, when once an established habit, could be gradually increased in sophistication. I delivered these forms to all the affiliates of CAGEO, in most cases by hand and with discussion and for the remainder by mail after a telephone discussion.

It took me in some cases three months of asking to obtain the record for one month. Eventually I got returns from five of the ten affiliates. From most of those, I obtained a fuller result than I had asked. In fact, their records were a formal presentation of the members problems about which, in most cases, I had been consulted in depth. For the results I did not get from the remaining five affiliates, I concluded that I was extending my role beyond any agreement I had established with them, and did not press the recording beyond the point of diminishing returns.

The data I had obtained in three months was from a small number of the most open and capable case workers. They inevitably attracted and worked with an unrepresentative group of troubled

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Geoffrey Sworder (Chapter 4 in Watts (1977), has three broad and descriptive categories which includes the majority of problems that come to work counsellors. They are reflected generally in the literature and arose out of my own collaborative efforts. These are:

"(1) Problems arising within the individual.
(2) Problems caused by the work organisation acting on the individual.
(3) Problems arising outside the individual or organisation

either (a) having visible effects on the work of the individual or (b) not having visible effects on the work of the individual. Sworder (in Watts op cit).

..../16

employees. The unsatisfactory result of this initial data collection and the causes both individual&organisationalwere insurmountable in the time available, and prevented me from developing hypotheses and completing an empirical research project.

Nevertheless, I have recorded the data collected for the month of June 1976, in Table 1 below. The figures in brackets came from the Shop Distributive and Allied Employees Association who at the time employed a welfare officer.

In summary, the research program became subsumed in the clinical-consultation role and if continued would provide another excellent early case finding system as well as a data base.

Table 1. Results of distribution of Record Form in Appendix IV for month of June 1976 from five A.C.T. Unions

Categories	Male	Female	Perm	Temp	Married	Single	Divorced or Deserted	20 - 30	30 - 40	40 - 50	50+
Stress at Work	10	4	11	3	12	2	-	4	4	4	2
Personal or Social Maladjust	(1) 2	2	(Ex) 4	-	(1) 3	1	-	3	(1) -	1	-
Stress outside work	(1) 2	(4) 2	(4) 3	(1) 1	(1) 2	(1) 1	(3) 1	- -	(5) 1	- 2	- 1
Compulsive Union Ringer	2	1	2	1	3	-	-	2	-	1	-
Other	(2)	-	(2)	-	(1)	(1)	-	(1)	-	-	(1)

SECTION II

Some practical - theoretical issues that arise from the foregoing OMH program in reference to comparable OMH programs elsewhere.

Preface

The foregoing report of the Master's placement is also the record of evolution of a skeleton role for which there were few

.../17

precedents in the A.C.T. There were some models in the OMH literature and these formed part of an ongoing role clarification and development and an ongoing integration of theory and practice. I hope to convey a comparative flavour of these models in the following pages.

Union - initiated OMH Programs

One of the most outstanding models is the "Cost-financed Mental Health Facility" for the United Autoworkers of America (UAW) at the Johns Hopkins Labor Union Clinic in the U.S.A. This began in 1966 and a number of reports have been written by the senior staff Herzl Spiro, Iradj Siassi and Guido Crocetti (referred to in Bibliography). These reports are: on field surveys to establish an epidemiological estimate of prevalence of "mental illness" among the adult enrollees (Siassi etal (1974)aand Spiro etal (1972) J. Nerv. Ment. Dis); an overall sociological examination of the population served and their attitudes to "mental illness" (Crocetti etal (1971) and (1974)); the "Clinical care pattern" and "Utilization profile" of the program and the "Economic issues and implications" (Spiro etal (Apr 1975) . Fundamentally this program, directed at an American blue collar union population, is a primary mental health care delivery system developed for this specific community. Its success is due in part to the goodness of fit between the service and its community. Financing aside, the program, staffed by a multi-disciplinary group, provided: (1) direct acute and chronic patient service, with an early case finding network which by the third year of the program received patients for treatment after an average of three weeks from reported onset of symptoms (a latency period of eight months was observed in a comparable outpatient service). Treatment modes used were crisis intervention, time-limited psych otherapy, family, network and group therapies and home visiting. The excellent links to the work setting enabled inexpensive treatment of thechronically ill; (2) primary prevention and promotion of mental health e.g. the mental health consequences of production line work were studied (Siassi etal (1974)); (3) a community consultation and education program which was in part designed to develop more appropriate utilization. Directed at the worker's family doctors, schools attended by worker's children, the shop stewards and union officials, the plant medical care and personnel systems, the churches

.../18

serving the worker districts and the union members' wives. This program led to a 100% increase in utilization in two years which has remained stable, as has the aforementioned three week latency; (4) consumer control through the collective bargaining arrangements which financed the program.

Another, well documented program, is that provided since 1964 at the Sydney Hilman Health Centre for the Amalgamated Clothing Workers of America (ACWA). The pilot of this program is described by the senior staff Hyman Weiner, Sheila Akabas and John Sommer in a number of articles (referred to in the Bibliography) and the program in the book by the same authors (1973). Again, it was designed for an adult American blue collar population, possibly more economically deprived than the UAW program.

A multidisciplinary team spent the first eighteen months of the pilot, building a rehabilitation network. The goal was direct participation of the union shop steward and officials, indigenous leadership, the health insurance company, management and the Health Centre in the rehabilitation process. Their main tasks were locating potential candidates for rehabilitation and modifying or changing jobs where necessary. A professional staff member was assigned to particular case finding channels and interracted with the workers at the shop floor - thus embedding themselves in the lay referral network. Their success in being accepted into this network was in part the result of their clinical approach resting on: (1) the assumption that the patient need not resolve all of his intrapsychic difficulties to achieve a work goal; (2) the active involvement of "significant others" (union, management and co-workers) in focusing on work as a goal of treatment (Sommer 1960). These are two aspects of goodness of fit between this service and its community.

Other union-initiated OMH programs in the USA are reported by J. Alexander (1969). Stone and Crowthers (1972) and Tureen (1966)).

In Australia, 1964, the Australasian Meat Industry Employees Union (Victoria Branch) established the first union Health Clinic. Les Cupper reported on this most recently (1975) when its future was in doubt. Initially, the Trade Union Clinic and Research Centre,

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provided a ten bed hospital with two major operating theatres. Subsequently, it closed the in-patient service, maintained other primary and secondary health care and introduced a Department of Occupational Safety and Health. The latter is likely to be the only Trade Union survivor to cater exclusively for the Industrial field, as the bulk of the Health Centres activities and management have shifted to a community base.

The Australian Workers Union, whose A.C.T. Welfare Officer participated in the CAGEO program, set up a mobile health screening and counselling service to 6,000 of their membership in a number of factories in Sydney. I have insufficient information about this program, but I understand that over 70% of the membership are women and that one in four were found to be committed to taking valium or other psychoactive drugs. This problem was most used as the point of entry for counselling.

Concluding Comments

A comparison of the two American programs is made difficult if not impossible, by the differences in the demography and epidemidogy of the two populations and in the research goals and diagnostic nosologies. The same applies and more so, to comparisons between these and the less well documented Australian programs and the CAGEO program - where cost-financing and Health Maintenance Organisations were only recently begun (I think in Wollongong in 1977).

However, the UAW and ACWA programs have distinctive features which were incorporated into my approach to developing a role in the CAGEO program.

These features are in general fitting the services to the community served. In particular: the development of early case finding networks through OMH education and embedding the clinician in the lay referral network: using work as a therapectic goal (rather than resolution of intrapsychics problems): andthe use of the significant others.

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However, and more importantly, the American programs enjoyed joint and direct worker-union-health insurance-management participation. The resultant role I established was amongst other deficiencies, peculiarly one-sided, embedded in a favourable part of the union lay referral network, receiving a selective clientelle with a union orientation to help seeking (as opposed to a management orientation - see Emery and Phillips Chapter 7 (1974)).

Non-Union Initiated OMH Programs

These are somewhat outside of the working area of this essay, but pose parallel problems and solutions.

A.G. Watts' book "Counselling at Work" (1977), describes a number of British work counselling programs. He raises these universal issues: the problems of transplanting into existing organisational structures conceptions of counselling which have been developed outside such organisations: the conflict of interests of and responsibilities to the individual and the organisation that arise when the organisation employs the counsellor and sets the boundaries of operation: the question of who should counsel - professional counsellors, line managers, peers etc: the necessity of fitting the structure for counselling appropriately to the organisations structure and 'climate: and, the evaluation of the effects of a counselling service.

Professional counselling programs at Shell Chemicals (U.K.), Guys' Group of Hospitals and Heathrow Airport are described. Two of these assumed responsibility for change within the organisation by mobilising internal counselling resources through consultation and training programs and through feedback to management about stressful work conditions.

Barnie Hopson in Watts (op cit) and Hopson (1973), describes the development of three counselling systems of "networks of employees who have been given some training in counselling and related skills but who are still primarily employed to do other jobs of work" (Chapter 7 in Watts op cit). These were: a Redundancy Counselling

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Scheme at British Steel Corporation; a Career Counselling Scheme which followed an intensive organisation development programme at I.C.I.; and a Peer Counselling Scheme at the National Environment Research Council. These raised fundamental issues of confidentiality, management support, the necessity of a support system for the counsellors in a network, training and the difficulty of containing its growth, using external resources, financing and evaluation.

Lepkin(1975) reports a variation on a peer counselling scheme iniated by the Management of an American Steel Corporation. A community health centre psychologist is invited in as a consultant by the untrained industrial counsellors, who were given this role part-time by management. The psychologist never gained the full support of management and the article reveals the considerable ideological and emotional conflict that occurred through his attempts to reach the foremen through management; finally, the whole program was dropped by management when the decline in the steel industry forced manpower pruning and re-allocation of staff.

Leeman (1974) and Leeman and Lavergna (1973) present another approach using a psychiatrist and a group of professionally trained counsellors. The program was initiated by the psychiatrist independently, and funded by government as a demonstration project. Its aim was to develop a Job Improvement Service for job-adjustment problems of lower-income employees. Of particular interest is the descriptionof the subtle and complex process of entry into the work organisations that he selected. He soon came upon the "unease" that companies and unions feel about "disrupting the very delicate stability of their working relationships" (Leeman (1974;). The population served were demonstrably unwilling to approach other helping agencies. Leeman's program was significantly assisted by the "projects autonomy with respect to management and labor organisations" and the emphasis it placed on helping "the employee to work out what was best for himself" (Leeman 1974). This free enterprise approach nicely sidesteps the conflict of interests problem. However, of the four private and two government employees, only one chose to continue the program at their own expense and that was a Bank! My guess would be that a significant reason for just this one continuing, was the goodness of fit of the counselling structure to the bank's organisation structure and climate.

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Other American programs reported in the literature are those of Felton and Swinger (1973), Franco (1967), Gomersall and Myers (1966), Kelsey (1975), Rowntree and Brand (1975) and Stoudenmire (1972); as well as in the related books e.g. by Kahn et al (1964), McLean (1967, 1970, 1974) and Noland (1973).

Concluding Comments

The practical problems of establishing a comprehensive, confidential, accessable and effective OMH program which gains the trust and active cooperation of the significant others in the work environment, are made all the more difficult if direct worker-union-health insurance-management participation is absent or diminished. It seems to me, that combination and outcome is rarely achieved without collective bargaining agreements for the program between the employees and employer (easy in a closed union shop) and cost-financing which provides accountability, consumer control and criteria for evaluation.

The industrial relations issue was inadequately prepared for in the CAGEO program and I struck the "unease" Leeman spoke of very early and, as well, within the union's affiliated with A.C.T. CAGEO. The CAGEO program lacked apart from sufficient time, some of the key participants (management, co-workers, families, members' doctors) and key elements (evaluation, a medical department, a team).

If the one-year CAGEO program could be judged as having some success it would be in terms of the goodness of fit between the structure of the program and that of the union organisation.

In many ways, the A.C.T. union organisation provides a good base for the application of a peer counselling model. In many ways and without premeditation, it was in the direction of that model that my role was developing e.g. in building information, training, supports and links into the already existing counselling resources and network.

SECTION III

Some theoretical and meta-theoretical issues that arise from a mental health approach to work organisations.

Preface

Alan McLean in his book "Mental Health and Work Organisations" (1970) stated that "any theoretical conception which seeks to embrace the influences of organizations on mental health must meet several conditions:

".It must bridge sociological and psychological phenomena, take account of forces at the individual, group and social structure" (and I would add physical and environmental)" levels and make it possible to trace the connections between one level and another." His other conditions are that it be part of a systematic theory of personality, be related to conceptions of stress, mental health and illness that are understood and recognised by clinicians, open avenues for more specific research and "facilitate development of means and modes of intervention to prevent ameliorateand alleviate emotional distress" (McLean 1970 p24).

My search for an applicable theoretical model has spanned some of these conditions. The cases of Messrs B and C and Mrs E challanged any narrow clinical approaches I may have entertained. Their distress arose out of interractions with their immediate psychological, social and physical environments, - turbulent environments interracting with other systems e.g. in the case of Mr B the competitive market place. The advanced state of work role breakdown that these cases represented, expose the complexity of origin of their problems and the diversity of solutions to theirs and the prevention of others'.

Table 1 represents the general areas which Ihave explored for applicable models. Weaving, snake-like through all the material has been the conceptualizations of Person-Environment fit and the means and modes of enabling a better fit e.g. between the individual and organisation, between the counselling structure and organisation structure.

The Person-Environment Fit Model

The Person-Environment fit model articulated by Kasl (in

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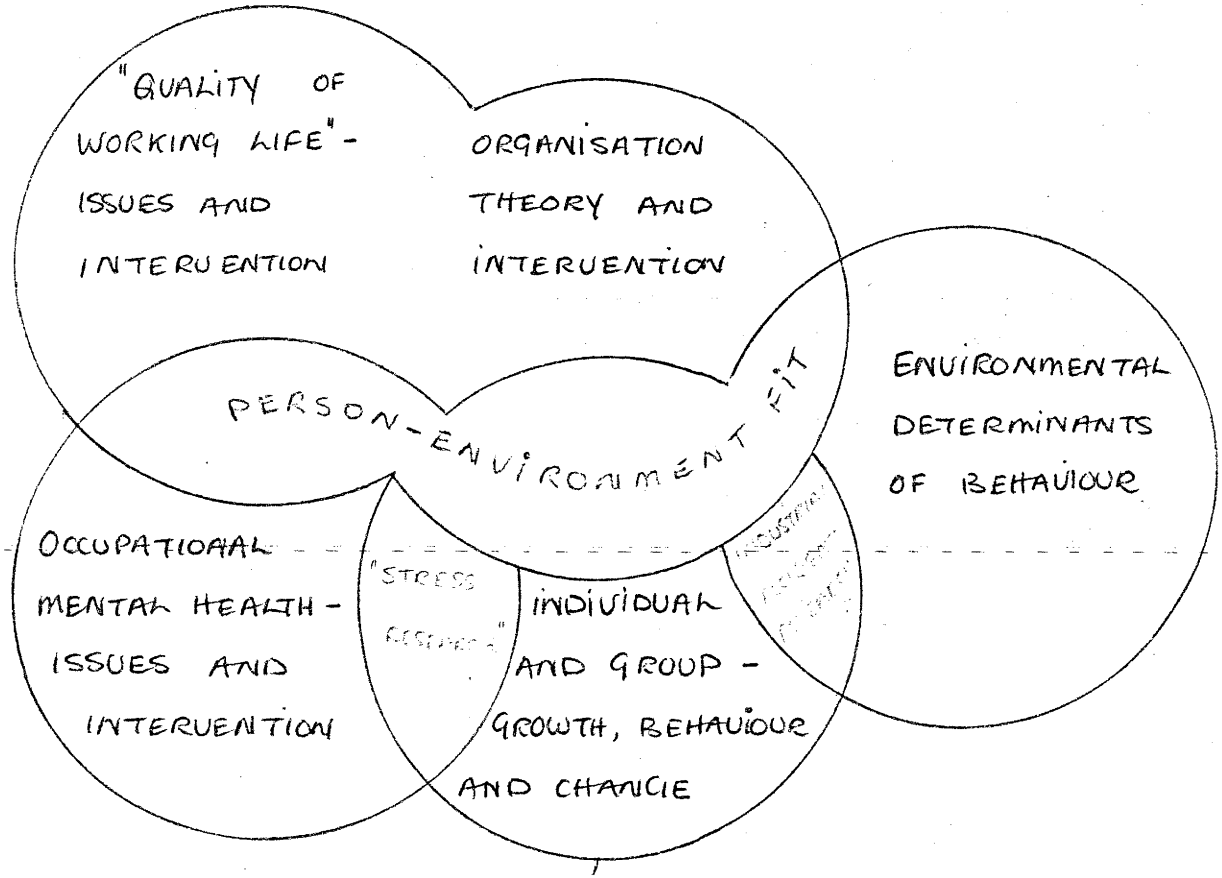

TABLE 1.

N.B. 'PERSON - ENVIRONMENT FIT' INCLUDES SUBJECTS OF JOB REDESIGN AND ENRICHMENT, ORGANISATION DEVELOPMENT, ROLE THEORY AND ROLE STRESS, FAMILY SYSTEMS THEORY AND INTERVENTION, NETWORK TECHNIQUES, ERGONOMICS, ARCHITECTURE AND OFFICE DESIGN.

O'Toole (1974))[3]. and by Carp (1968), French and Kahn (1962), Kahn and Wolf (1964), Kahn and Guir (in McLean 1970) and Lofquist and Dawis (1969), seems to me to be best able to fulfil McLean's criteria.

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"This model integrates several elements and processes: (1) the dimensions of the work environment that are job demands (requirements) and those that are resources (need satisfiers); (2) the dimensions of the person that are his abilities (resources) and those that are his needs; (3) the relation, in particular the discrepancies, between the demands and the resources in the environment on the one hand and the needs and abilities of the person on the other, and (4) the consequences of these discrepancies including attempts to alter them. Within the P.E. model, it is useful to distinguish between objectively measured and subjectively perceived (or misperceived) dimensions of P (self) and E (environment) and between coping that alters dimensions of P.

The P.E. model is only a very general and rather abstract perspective from which to view the issue of work and mental health. One consequence of adopting this perspective is the realization that while the dimensions of job requirements and of the corresponding abilities in the person have been frequently studied in the traditional vocational fitness literature, the dimensions of the person that represent hisneeds and the dimensions of the job environment that represent resources (satisfiers of needs) have been neglected.....Another consequence of the P.E. fit perspective is the recognition that job satisfaction measures are interraction measures and do not reflect the dimensions of either the person or the environment alone.....This perspective also forces us to pay more attention to the dimension of time and to the process of coping with various types of P.E. "misfits". Job satisfaction measures are too static and,in fact, tend to disguise anddistort the whole process of man's adapting to, and coping with, the discrepancy between his needs and satisfaction of these needs by the work environment..... .....The almost limitless plasticity and adaptability of some workers is seen in studies that suggest that even very repetitive and routine work can be satisfying; apparantly some workers prefer mechanically paced, highly structured jobs and find some satisfaction in their very rigidity and mindless but predictable triviality." S. Kasl pp 183-185 in O'Toole (174).

J.R.P. French (p 70 in A. McLean 1974) describes two kinds of fit between a person and his/her jobenvironment. One is the degree to which his/her skills and abilities match the demands and requirements of the job. Another is the degree to which the needs of the person are supplied in his/her job environment e.g. the extent to which his/her need to utilize his/her best and highest abilities is satisfied by the current job. French's basic assumption was that misfit on either of these will cause job dissatisfaction, depression, physiological strains and other symptoms and poor mental health. In testing hypothesis derived from this assumption, he found that (1) there were too few cases of a strong discrepancy between what a person has and what he/she wants(2) measures of fit, like other discrepancy scores, tend to be unreliable (3) the measurers were probably biased by wishful thinking and dissonance reduction. He suggested solutions to these problems lay in improved methods of analysis e.g. developing more differentiated concepts and measures for describing role stress.

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The P.E. model suggests a number of major points for OMH intervention to alleviate, ameliorate or prevent damaging levels of stress. "These may be (1) characteristics of the person (such as task and coping abilities, motives, or needs, and styles of responding to situations); (2) characteristics of the environment or social structure (such as levels of work load, responsibility, social support, degree of competition versus cooperation, and participation in decision - making); or (3) both kinds of characteristics simultaneously." (House pp 164-165 in O'Toole 1974). The latter item (3) involves intervention in the very "process of man adapting to and coping with, the discrepancy between his needs (and resources) and satisfaction of those needs by the work environment" (Kasl p 185 in O'Toole 1974)

Comparability of OMH Programs

One of the handicaps to developing effective intervention strategies is the inadequate knowledge of the influences of organisations on mental health. The majority of studies that embrace this influencehave used job satisfaction as the only indicator of mental health outcome (see Kasl's review,op cit). Within the P.E. model this is an interraction measure which does not reflect the dimensions of the person or the environment alone. So comparison and generalization is limited. The same applies to the OMH programs reported here. They are often intuitive - yet systematic attempts to intervene in person problems, case by case, and from an interractionist point of view.

Likewise, the organisation interventions (e.g. in Volume 2, Davis and Cherns (1975); Part III of J. Hunt (1972); D. Gunzberg (1975).) deal with work environment problems case by case and also from an interr actionist point of view. Comparison within and between these two fields ofintervention (i.e. OMH and organisation) is limited in part because the strategies deal with unique processes of interraction. The cases of both fields demonstrate "models of systems of relation in action" and correspond to an indispensable phase of scientific development.....the exploratory phase "(Crozier p.4 (1964)). Davis and Cherns call this phase "action research", and they report a solution to some of the problems

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of comparability of quality of working life studies and intervention. That is, by specifying minimum criteria that all case studies and interventions should meet in measuring and reporting (Davis and Cherns, Chapter 4, Vol two, (1975)). I am aware of no such attempt at solving this problem of comparability in the OMH field - and in fact reports of OMH programs are as incomparably diverse as are the definitions of mental health and illness implicity or explicitly used.

Relationship of Organisation Intervention to Family Therapy

Of particular interest to me, however, is the comparability of and cross-fertilization possiblebetween, these two fields of intervention. The connecting link for me has been the applicability of the P.E. model at both the organisational and family levels. At the family level, the P.E. model contains the elements and processes that family therapists intervene in i.e. the individuals needs and resources, the families demands and resources and the processof coping with and adapting to the discrepancies between the individuals needs and the satisfaction of those needs by the family.

The meeting place of organisation intervention and family therapy is beginning to be articulated in the mental health literature. The exponents of the family Systems Model of Murray Bowen are one group reaching across. An example of this is S. Minards' (1976) article, adapting family systems theory to organisational dynamics. Likewise the exponents of Network assembly (e.g. G. Erickson's (1975) summary of the field; Speck and Attneare's (1973) description of the process; and Garrison (1974)), have techniques which are and have been directly applied to organisations. Polak's (1971) article makes some of the links with organisation and systems theory and intervention. Whilst Ladbrooks (1978) article describes the application of Delphi techniques to life reconstruction for the divorced. Clearly, this is an area I would like tohave explored more in this essay.

..../27

SECTION IV

Conclusion and Recommendations

The intention of this section is not to reiterate the concluding comments from throughout the essay, rather to return to the purposes of the essay. These were two fold - to report an exploratory application of the community mental health (C.M.H.) model outlined and to explore the practical and theoretical issues that arose as a result.

Firstly, the C.M.H. model suggest a comprehensiveness of service that could not be fully realised within the resource limitations of the CAGEO program (particularly of time and access to and participation of significant others). Furthermore it is highly unlikely that the C.M.H. model would ever fit the current management, union, work and health insurance ideologies. Occupational mental health is one of the least significant industrial relations issues in the A.C.T. (-the idea of worker participation is hardly off the ground; public service unions remain large in number, fragmented in representation of workers in the same office, and divided in priorities; the Public Service Board has just concluded its joint council report on staff counselling).

Within these industrial dimensions, the Peer Counselling Model would be a better fit, both for the interested and committed CAGEO affiliated unions and for participating public service offices. The emphasis of this model on presently committed resources and practice would lead to localised effort in supervision, counselling, training and education.

In addition to recommending the Peer Counselling Model, I would also recommend its application to one union organisation at a time.

Secondly, as a clinical psychologist I have always worked in a ready made practitioner system (e.g. a health commission) and with a client system both no larger than the family and with ease of access

...../28

to significant others (teachers, grandparents, etc). Engaging a client system as large, pluralistic, and fragmented as CAGEO affiliated union organisations, together with the work environments that are a prime focus of this client system, was a whole new game to me. Developing an effective, broadbased role within that system that is not subordinate to a particular value and power subsystem, requires considerable organisational knowledge and skills on the part of the practitioner and broadbased commitment on the part of the client system.

I would recommend that considerably more time and attention be paid to the engagement of the client and practitioner systems and to premeditation of the context and focus of intervention (see A.W. Clark, Chapter II and P.A. Clark Chapter 12, in Davis and Cherns (1975) Vol 2).

Looking Forward

I would have liked to explore further the areas of (1) cost-financing union OMH program using the Health Maintenace Organisation concept; (2) organisation intervention theory; (3) the relationship between family and organisation levels in theory and intervention; (4) the generalisation or compensation effects of work roles on other life roles, and vice versa (5) the usefulness of a role stress, PE model, in predicting mental health outcomes.

In my "back home" job, the significance of the OMH program to CAGEO has been incorporated in a proposal to establish an Occupational Mental Health Unit in the Health Commission (see Stage III report of Mental Health Branch).

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APPENDIX I

Peter J. Fox,

19 January 1976

Secretary,
C.A.G.E.O.,
P.O. Box 172,
CIVIC SQUARE. A.C.T. 2608

Dear Sir,

I wish to apply for a placement with C.A.G.E.O. in the area of occupational health (e.g. counselling) and/or other psychological service (e.g. research). A placement in an organisation is a requirement of the Master of Science in Applied Psychology course which I am undertaking full-time this year. I am particularly interested to pursue the work with C.A.G.E.O. and affiliates which I became involved in last year.

What is involved for C.A.G.E.O. is the following:

1. Provision of a field of work in occupational health or other psychological service for one day per week beginning any time in March and ending no later than January 1977.

2. Provision of a supervisor in C.A.G.E.O. with whom to communicate my activities and with whom my A.N.U. supervisor, Dr. W. Gladstones, may confer regarding my activities.

3. No financial expense is necessarily involved.

In addition to the work I do with C.A.G.E.O., I will provide C.A.G.E.O. with a written report at the end of the placement describing my activities, the results, evaluations etc. Also I intend to write my "thesis" essay on the topic of "Psychological Service with Employee Organisations".

My activities with C.A.G.E.O. will be pursued under the principles of confidentiality and professional conduct provided in The Australian Psychological Society Code of Professional Conduct.

Yours faithfully,

P. J. Fox

Peter J. Fox
Psychologist

COUNCIL OF
AUSTRALIAN GOVERNMENT
EMPLOYEE ORGANISATIONS
A.C.T. DIVISION

P.O. Box 172,
Civic Square,
A.C.T. 2608
Phone: 81 0511

11 February 1976.

Mr. Peter J. Fox.
120 Captain Cook Crescent,
NARRABUNDAH. A.C.T. 2604

Dear Peter,

Thank you for your letter of 19 January 1976 app'ying for placement with CAGEO in the area of occupational health.

I am pleased to advise that the Council at its recent meeting agreed to accept your offer to work for CAGEO during the next twelve months.

In order to determine the best method of using your service, I have been asked to arrange a meeting between Dr. Gladstones and yourself and members of the Executive of the Council. Accordingly, it would be appreciated if you would contact me with a view to determining a mutually acceptable time for discussion.

Yours sincerely,

P. Wright
Divisional Secretary.

MENTAL HEALTH BRANCH

APPENDIX II

RESOURCE DEVELOPMENT CENTRE

Helping Distressed People

Many situations can upset and worry us. Sometimes these feelings can stop us from solving quite simple problems and we may find we cannot easily cope with day to day activities whilst the upset lasts.

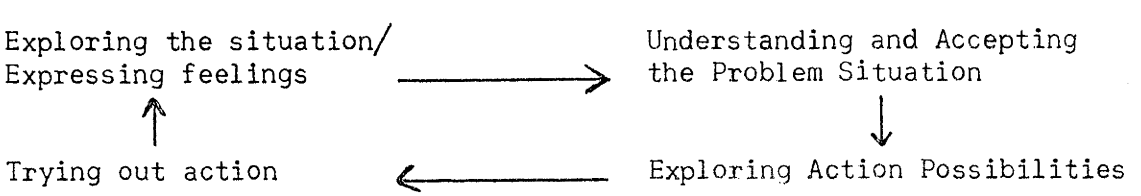
Events which are particularly distressing include:-

- being demoted, fired or retrenched
- bereavement
- disciplinary action at work
- accident, injury and illness
- marital friction or breakup
- sitting for exams
- choosing or changing a job or career
- making major family or work decisions
- retirement
- changing cities
- friction at work

It is usual to feel uncertain, irritable and at times anxious or depressed during such events. Then, above all we depend on family and friends and work mates for assistance, acceptance and concern. When no family or friends are available, or when they too are upset and/or inexpert in dealing with the source of distress, then outside help may be necessary. It is often in these circumstances that the Union or Association is called upon.

Without this help, failure of health, loss of job efficiency and pressure leading to personal breakdown may follow. With appropriate help, however, the person and/or family may be strengthened and learn new skills, new ways of coping. People who are upset are more open to influence and trying out new approaches. A time of trouble can thus have a very positive impact.

Any upsetting situation seems to be handled best by the following steps:



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This forms a learning cycle, as taking action generates a new situation to be explored. In complex problem situations, people may need to go through the cycle several times. If someone helps me through this cycle, I may not only resolve my current difficulty; I may learn to be more effective when next facing difficulties.

The following list of suggestions can be helpful in assisting people faced with difficult situations.

(a) Show your interest and concern; show you are paying attention; tell him what you understand him to be saying.

(b) Help the person confront his situation, to talk about it, to realise the dangers, pain and trouble, to reveal unspoken fears. If he needs to, help him to grieve, cry, or to be angry. Listen to and accept his feelings as real for him.

(c) Help him confront the situation in manageable doses. No-one is strong enough to look at an alarming situation without some relief.

(d) Help him find the facts. The facts of illness and difficulties are often more reassuring than speculations made in ignorance and often not voiced.

(e) Do not give false reassurance. The "there, there, everything will be alright" approach is no help to a person in trouble.

(f) Do not encourage him to blame others; look more for what he can do about the situation.

(g) Assess the supports in his environment and mobilise them to his aid.

(h) Understand the unique personal meaning of the distressing situation to him and his unique perception of the situation.

(i) When you have listened, check that you have understood; then look at what can be done. Action before understanding is blind. Understanding without action is empty.

Compare these suggestions with the actions of people who have helped you at a time of trouble and see if these describe what was, in fact, helpful to you.

MENTAL HEALTH BRANCH

RESOURCE DEVELOPMENT CENTRE

Taking over vs working together

At times of trouble (illness, bereavement, breakdown, distress etc.) a little practical assistance can make a big difference to how we cope. Illness, bereavement and breakdown can be very incapacitating, so much so that practical tasks which are normally easy become very difficult or impossible. This can remain so for some time after the precipitating event. Sometimes, the person may appear to lose the capacity for self care but will flourish in response to interest and encouragement.

Example I

Jenny approaches the union organiser, Bill, for some help about meeting new people socially. She has been recently deserted by her husband and is trying to get on her own feet. Jenny is struggling to develop her own resources and feels uncomfortable in asking others to help her. Bill could assume that Jenny wants him to arrange some social outings for her.

Example II

An unemployed, isolated man who is physically well has gradually stopped going out. Now his nutrition is suffering as he rarely shops and often goes hungry. Some of his mates at his last job got wind of his troubles and start a roster to make sure he has food in the house. The man fears he will be left alone again if he does go out himself. He is using the threat of malnutrition to interest people and gain their time. An issue is shop for him or with him?

There is danger in helping out. A person who gives up activities to someone else (as in Example II) or hands over responsibility (as could happen in Example I) may learn such lessons as "If I look helpless enough someone will take over" and "I can't cope". This can be very tempting for someone who is upset and worried, but it leaves them less able and willing to cope in future.

What happens depends a lot on your actions and attitude. If you act as if the person is helpless and you take over many activities, he or she may come to believe they are helpless and will always need assistance. If you act as if the client is a capable person who needs some temporary help to cope with an overload, and try to work with the client, he or she learns that they are capable and can cope.

Some people want to dump everything. Most are grateful for some help but are likely to resent a helper taking over. It is wise to discuss what you are doing with the client and see what he can do with you. Even for someone who is very upset, being active in some routine tasks can help. If you find it necessary to take over, always be alert for opportunities to involve the client again in what is probably a normal activity. Practical assistance which relieves unmanageable overload is helpful but not if it fosters giving up.

Respect the person's capacity to cope and challenge it in manageable doses.

MENTAL HEALTH BRANCH

RESOURCES DEVELOPMENT CENTRE

Negotiating a Contract

Two people make a "contract" when each agrees to do something the other wants in return for the other doing something. It is an exchange or trade of desired actions - "You do what I want and I'll do what you want." The key points in a "contract" are that:

1. It is explicit - what is agreed is stated explicitly and is clearly understood by both parties.

2. It is reciprocal - each party agrees to do something the other wants if and only if the other party reciprocates.

3. Actions are exchanges that are observable so both can see if the agreement is being kept.

4. It is mutually acceptable - both parties agree it is a fair exchange and both are willing to do their part.

Where to use and where not to use contracts

Mostly people who have a relationship that continues are reasonably satisfied with what they obtain for what they do - even if this is quite altruistic, as when a helper gains the personal satisfaction of being helpful and effective, and the person helped does no more than make good use of the help given. In most relationships, "contracts" are not necessary.

Where a relationship is not satisfying, working out a "contract" may help to improve matters. This can be very effective with some over-demanding or over dependent clients such as a compulsive union ringer. On the other hand, in recruiting for membership of the association, the organiser may initially have little to offer in a concrete way that the prospective member values. There is little basis for negotiating a contract. Signing the application for membership involves a non-negotiable contract i.e. agreement to abide by the rules of the Association.

Some Examples

1. Some members demand more and more help and emotional involvement from organisers. The member may have mixed feelings about taking action to resolve the situation, and resist in various ways. In such a case the organiser may have to negotiate an agreement with the member. The member may be avoiding action as this would end the member's reason to receive attention from the organiser. An appropriate contract might then be:

   - The member agrees to take appropriate action, one step at a time.
   - The organiser agrees to talk to the member at a particular time, for 5 minutes if the member has not completed the task, and for 30 minutes if the member has completed it.
   - Both agree to review this arrangement after a fixed period (say 4 weeks).

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2. With a member who is very anxious and demanding and merely wants attention at any time an appropriate contract might be:

   - The organiser is available to give the member undivided attention for two agreed on half hours each week.
   - The member agrees to ring only at that time unless there is a "real" emergency.
   - Both agree that the organiser is the final judge of what is an emergency. Time spent outside the agreed periods which is not truly on an emergency will cut the agreed time by a similar amount - e.g. 10 minutes of unnecessary contact cuts 10 minutes off the 60 minutes of scheduled contact.

Making a "Contract"

1. Each party specifies actions desired from the other.

2. Each openly states whether he is or is not agreeable to doing what the other wants, item by item.

3. They negotiate about any discrepancies between one party's desire and what the other will agree to. Compromises are often necessary and possible.

4. They agree on the exchange of actions, item by item.

5. The contract is explicitly stated including all limits needed, e.g. a date for review.

"Contracts" and Limits

Sometimes limits to what a helper will do must be set that are not really acceptable to the client and do not depend on any action by the client. Such limits are not a "contract" as there is no mutually acceptable exchange.

APPENDIX III

PROPOSED RESEARCH PROJECT

Pattern of consultation of employees in trouble.

Often the union is the last place of call of members who are troubled or in trouble. Likewise , recognised resource people in the work environment are the last to know. In both cases the consultation occurs far too late in the process that leads the employee to awareness and resolution of his trouble.

The proposal is to investigate the pattern of contacts, the process of consultation, which employees follow when troubled. Through this to discover what provides satisfactory outcomes and what leads to maladaptive processes from the viewpoint of the employee.

To achieve this it would be necessary to collect initially rough forms of information from present contacts with CAGEO and affiliates and perhaps from past employee contacts. After obtaining a grouping of this information e.g. into source problems, source departments, sex, age, etc., it is proposed that one or a number of these groupings be investigated more intensively through the employee concerned and his sources of help and consultation.

Potential outcomes of this project may be:

1. a lead on what are adaptive and maladaptive responses when an employee/union member is troubled or in trouble. Arising from this may be an education program for the membership informing them of successful methods and sources of aid when faced with certain classes of problems.
2. highlight the more useful patterns of communication between the union and members and families and between the union and employers and/people within work environments.
3. stimulate negotiation of patterns of consultation when a person is faced with a certain type of problem , in other words to provide agreed upon paths of consultation between the union, the employee and the work organisation.

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OUNCIL OF
USTRALIAN GOVERNMENT
MPLOYEE ORGANISATIONS
.C.T. DIVISION

P.O. Box 172,
Civic Square,
A.C.T. 2608
Phone:

June 1976.

TO ALL SECRETARIES OF AFFILIATES

OCCUPATIONAL HEALTH COUNSELLOR

RESEARCH PROGRAMME

As you are aware I have been engaged by CAGEO for the next nine months to undertake a research programme concerning Occupational Health.

I can be contacted on any Thursday during business hours at the office of the APSA (FDO) 3rd Level, Woden Churches Centre, Telephone 81.0511. On ~~Mondays~~ other days I may be contacted (telephone only) ~~49.4003~~ 95.0051

I am readily available for consultation on all matters relating to Occupational Health and am very interested in being with union officers/organisers when they are interviewing members whose problems are primarily those of work related stress due possibly to a personality problem or any other stress related problem which affects them in their work environment, e.g. noise, victimisation, unjustified disciplinary action, etc.

I am presently engaged in the training of shop stewards. This training includes sessions on how to assess certain aspects of members problems and the skills necessary to communicate with a member when a problem becomes apparent. I am very interested in expanding this or similar training to other areas in the Union organisation.

The attached paper will explain a "Preliminary Occupational Health Survey" project which I am presently researching and I rely heavily on your co-operation to bring this programme to fruition.

If you are interested in further discussing any of the above matters please contact me on either of the above numbers.

P. Le Farmer

for PETER FOX
Masters Student/Psychologist

COUNCIL OF AUSTRALIAN GOVERNMENT EMPLOYEE ORGANISATIONS

A.C.T. DIVISION

PRELIMINARY OCCUPATIONAL HEALTH SURVEY

INTRODUCTION:-

The purpose of the enclosed Record Form is to begin a rough record of the number and nature of members who bring a problem to the Union, which, in the Organiser's assessment is not strictly industrial. A problem which borders on, or is in fact, "Occupational Ill Health".

For the purpose of the survey I have roughly categorised below the types of occupational ill health problems. In all probability the use of these categories will show some anomalies and lead to their amendment. These categories are:-

A. STRESS AT WORK

The problem arises primarily from short or long term psychological stress caused by some aspect of the work environment, e.g. stressful job style, conflict with a particularly difficult person at work, conflict of rules, noise, etc.

B. PERSONAL OR SOCIAL MALADJUSTMENT

The problem arises primarily from a failure on the individuals part to make an adequate personal or social adjustment, e.g. those members described as "their own worst enemy", or those members who don't "fit in" with the work they are doing, i.e. vocationally misplaced, or those with a "personality problem", e.g. alcoholism, etc.

C. STRESS OUTSIDE WORK

The problem arises primarily from stressful situations outside of the work environment, e.g. at home, with money, etc.

D. COMPULSIVE UNION RINGER

Self explanatory - rings the Union about everything or nothing. The member with the problem is a "compulsive Union ringer".

E. OTHER

e.g. Combinations of the above (as in some cases of victimisation).

In ccompleting the Record Form you may have to make an arbitrary decision about whicch category best describes the member's problem. If in any doubt please writte a brief description of the problem.

..2/..

Please begin recording those cases that come to you from now on and return the completed record form at the end of the month. You only need to record the same member once in a month's record and subsequently in each month thereafter whilst he/she maintains contact with you.

If you have any criticisms, suggestions, problems or just chat, I can be contacted at APSA (FDO) office on Thursdays, 81.0511, and on ~~49.4003~~ 95.0051 on ~~Mondays~~ other days of each week.

At the end of each month I shall pick up the completed or blank record form, this will enable you to discuss with me any relevant problem.

Thank you for your co-operation.

for Farmer

PETER FOX
Masters Student/Psychologist

PRELIMINARY OCCUPATIONAL HEALTH SURVEY - RECORD FORM

1. Name of Union or Association .....

2. Are you employed full-time in the above Association/Union Yes/No

3. Return for the month of .....

4. Code for categories (last column):-

   A. Stress at work
   B. Personal or Social Maladjustment
   C. Stress outside work
   D. Compulsive Union ringer
   E. Other (Please describe briefly)

NOTE: Description of the above codes in introductory paper.

ex and pprox. age	Perm/ Temp	Maritial Status	Dept.	Designation	Problem (see 4 above)